DISABILITY CERTIFICATION FORM

If you are applying for special testing accommodations due to a disability, this form must be completed by you and an approved professional and returned to our office thirty (30) days prior to the testing date. Upon receipt of this form, our office will then: (a) determine if the applicant qualifies for special testing accommodations, and (b) if so, determine the type of special testing accommodations to be provided. **All recommendations are subject to approval by the department. If questions arise, the signing physician will be contacted.**

Failure to complete and return this form 60 days prior to the testing date WILL prevent our office from making special testing accommodations for the examination you are applying.

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This section is to be completed by the applicant.

Applicant's Name:_____Date:_____
(PRINT)

Applicant's Name:_____
(SIGNATURE)

Applicant's daytime phone number:_____

License Title Applying:_____

Did the professional or vocational school that you attended provide you special testing accommodations? Yes_____ No_____ If yes, provide a statement from the school explaining how you sat for examinations.

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This section is to be completed by approved professional. The signing physician MUST BE QUALIFIED IN THE SPECIFIC DISABILITY AREA AND WITH THE SPECIFIC POPULATION. See attached.

Type of disability:

Physical____ Mental____ Learning Disorder____

Diagnosis:_____

Name of test(s) used:_____

Length of time with condition:_____

(Continued on next page.)

Recommended testing environment:

Special lighting____ Separate room____ Other____ (specify below)

_____

Recommended format of test: (check as many as appropriate)

large print____ Braille____ proctor to read____

tape recorded____ sign interpreter for hearing impaired____

additional testing time (specify recommended amount of time)____

Recommended recording of test answers:

typewriter____ proctor to mark answers____ other (specify below)

_____

Our office will determine the time allotted for the examination.

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Professional completing certification:

_____ _____
Name (please print) Date

_____ _____
Name (signature) Title

_____
Address

_____ _____
City, State, Zip Code Daytime telephone number

_____
License number (if applicable)

_____
Employer name (provided only if you are not licensed)

PLEASE RETURN THIS FORM TO:

BOARD FOR PROFESSIONAL ENGINEERS AND LAND SURVEYORS
2535 CAPITOL OAKS DR., STE. 300
SACRAMENTO, CA 95833